Chronic Care Management Data Questions & Answers

Questions	Answers
Confirm if the frequency of availability of the eligibility file is monthly.	Yes.
Payee ID is filled with either null or * in the files, what does this field indicate?	That is an identifier we had to strip out.
GROUP_NO is either null (60,633 records) or 9999 (29 records), what are the values for this?	This field is not relevant; we should have removed it. Associated with third party liability.
There are multiple values in this field PCOP_TERM_CODE but no associated code table I can locate. What are these values?	PCOP Term codes are assigned when a person terminates from managed care or disease management. A = loss of Medicaid B = loss of managed care C = changed CSO's D = changed plans E = exempted from managed care F = some other termination G = SSI eligibility H = eligible for Medicare I = third party liability
There are multiple values in this field MATCH_CODE but no associated code table. What are these values?	See Medical Decoder Key attached.
RECIP_RES_ZIP is a 3 digit zip. Will you provide the entire 5 digit zip code?	No, HIPAA only allows 3 digits.
There are multiple values in this field client No but no associated code table. What are these values?	These are created for the purpose of linking the two files.
MEDICAL_CODE is either null (60,633 records) or 9999 (29 records), what are the values for this?	See Medical Decoder Key attached. 0 = Medicaid only.
Missing Critical fields: Date of Birth, First Name, Last Name, Address, City, State, Phone Number, Termination of Benefits Date, Physician Information (Including Contact Information). What about Carrier ID and full ZIP?	We can not provide the fields listed per HIPAA rules. Carrier ID-Way to associate claim with the entity covering the service which may be relevant if there are multiple claim sources involved; e.g., other State of WA government agencies. Full zip - a 3 digit zip is all that HIAA allows us to transmit.
What does the client NO reference? Is this the unique identifier tying the eligibility to the claims information at a member level?	Client number references a specific client. Yes.
What does ICN reference?	ICN = internal control number, used to track individual claims through system.
There are multiple values in this field "claim type" but no associated code table I can locate. What are these values?	J = physician, D = drug, K = dental, P = med vendor, T = nursing home, M = outpatient, R = DRG, S = Inpatient, RCC, W = Outpatient crossover claim, V= Inpatient Crossover claim.

Does the CAT_OF_SVC information tie to the Place of Service Code table provided?	CAT_OF_SVC is an internal mechanism used in conjunction with PROV_TYPE and PROV_SPEC to determine provider reimbursement and eligible services.
The field PRIMARY_DIAG looks to contain different types of codes. What types of codes does this field contain? ICD-9??	Primary Diagnosis should refer to ICD-9 codes. However, if ICD9 was entered incorrectly by provider, it might be transmitted in this file, and would still show up at header level.
Values in the field TYPE_OF_SVC are Null, 1-9, R, and Z. I do not see an associated code table that defines all of the values provided in the data. Are these PCOP types?	Those would refer to exemptions.
Does the field CPT_PROC_LINE contain only CPT codes?	No. ADA Dental diagnosis codes are included in this line.
Revenue codes are 4 digits with a leading zero, should the leading zero be removed?	Yes, remove leading 0.
All dates provided only include the year; we would need to receive the actual day and month included as well.	Cannot provide per HIPAA.
It appears there are Pharmacy claims included in the file, do the financial fields include both medical claims and pharmacy claims?	Don't know what your question refers to – dollar amounts? If you are referring to dollar amounts in the file for pharmacy, those amounts would appear at the header level.
Is there a way to separate the Pharmacy claims from the Medical claims?	Yes, pharmacy claims are D type. However, pharm claims also show up on medical claims – could separate using rev codes.
Missing Critical (Medical Files) Date of Birth, Is Beginning Date of Service captured in field 33, Is Ending Date of Service captured in field 34, Date Claim was paid, First Name, Middle Name, Last Name, Admit ID (code associated with each unique hospital stay to group claims for each admission), Discharge (code indicating where member was discharged to), Length of Stay (or beginning and ending dates of services). Unique Identifier for Medicaid recipient (example SSN or other unique value). Is the unique identifier client No?	<u>We cannot provide these fields</u> Answer: Yes
Will the State please clarify the relation ship between the members in the claims file (DMClaimInfo) and the eligibility file (DMRecipInfo). Preliminary analysis indicates that there are ClientNo's in the claims data which do not appear in the eligibility file.	The client eligibility file contains only those clients who were eligible for the current month. However, claims data was created for 12 months of utilization for all clients who had been eligible during all 12 months. Therefore, the claims data set includes clients who are no longer eligible and those clients would be excluded from the eligibility file.
Will the State please explain the criteria used to extract the claims data - specifically the dates of service, dates paid and member eligibility requirements if any?	Claims were pulled for clients who were considered eligible for the previous Disease Management program. Those criteria are found on the last page of this Q & A document. The dates of service range from April 2004 through May 2006; however there could be claims prior to 2004 based on dept policies and procedures.
Will the State please explain the criteria used to extract the eligibility file data - particularly in regards to - but not limited to the time frame for the eligibility? Preliminary analysis indicates exactly the same number of members appear in both the claims and eligibility file, suggesting that the eligibility file may be a roster of utilizing members as opposed to a list of all member having eligibility in the period.	Client eligibility is a current "snap-shot" of client program eligibility. Claims were pulled for the entire "enrolled" population. There are clients who are not active DM participants in the eligibility file. Very few SSI clients are likely to have zero claims in a 12 month period.
Will the State please provide five -digit zip codes for the members appearing in both the claims and eligibility files? Barring that would the State please provide the county of residence for the members appearing in both the claims and eligibility files?	No - to comply with HIPAA guidelines for release of Personal Health Information we cannot release that information.
Will the State please provide a valid values list for the CAT_OF_SVC field appearing in the claims file?	Please refer to the data dictionary

Will the State please verify if the mental health claims, with DSM-IV diagnoses, processed via the Regional Support Networks are included in the data set provided?	**No, RSN capitated payments are made through a different payment system and are not included in this data set.**
Will the State please provide exact dates on claims - specifically first date of service, last date of service and paid date?	No - to comply with HIPAA guidelines for release of Personal Health Information we cannot release that information.
No data of service or month of service is provided in the data. Please confirm that it includes all of calendar year 2005 data, plus a portion of 2006 data. What is the end month for the 2006 data? In the 2005 data?	The data files do contain at least twelve months of paid claims, including most of calendar year 2005 and a portion of 2006. You will also find data for 2004 and 2003. Albeit, these 2 years do not have complete claims data. The data pull begins 4-1-04 through 5-1-06. Because of Department policies claims prior to 4-1-04 will be found.
On the disk, only one month of eligibility data per beneficiary has been provided – the most recent month. How may a potential bidder obtain beneficiary enrollment spans that relate to the "dates of service" provided in the claims data?	The exact client coverage status would be unknown. Because this is a test and the claims data references paid claims data, all clients are assumed to have eligibility under some program administered by DSHS at the time of service. For testing purposes you can make the assumption that all clients listed in the eligibility files are covered for all dates of service, regardless of the span of eligibility dates, some dates of service or the program that the client is on does not support the scope of the RFP.
Can DSHS please explain what the "YearFDOS" field contains? The values range from the year 1930 to 2025 and there are also null values.	There are a number of claims that have some very old dates, back to 1999, which could be causing issues with formatting. These claims should be considered an exception to the rule based upon the premise of payment beyond normal billing time lines. FDOS=First Date Of Service.
Please define the potential data items in the field "claim_type ". We have noticed that type "K" has over 236,000 lines associated with this type code and for code "D" there are over 120,000 lines. In the answers to bidders questions from July 20th, on page 30, question number 56, it indicates DSHS will post the Data Dictionary on the website. This information is necessary to interpret the data on the disk. When will this information be available?	See Data Dictionary Definition
We noticed some claims data for which the "client_no" was present in the claims detail file but not present in the recipient data file. What is the cause of this occurrence and should we expect this to occur in the actual claims data provided by DSHS? (i.e. 22,000 enrollees in claims filer were not in the recipient file based on client number).	Yes, you should expect that you may have claims for clients but not a matching eligibility file. The recipient file looks at current segments of client eligibility. Based on retroactive client eligibility the claims file may not match. In the new program, you would expect to only receive claims for clients you had at least one month of eligibility information on.
Will actual claims detail anticipated to be received monthly continue to include client data duplicate fields (such as age, sex, program code, zip, etc) or should we expect that actual files will only include the "client_no" as an identifier?	Actual files will have actual client identifiers, by then you would have a business associate agreement and we will share data.
What does "recipient exception indicator" represent in the sample claim file?	See Data Dictionary for definitions. The field represents internal coding based upon client restrictions.
Should we expect the actual client information to remain consistent with sample file's dispersion among the various zip prefixes?	There may be reasons for all kinds of changes to dispersion, but no systematic reason.
In the answers to Bidders questions from July 20th, on page 24, question number six (6), it indicates that "DSHS will provide supporting information for rate determination such as number of enrollees in the previous disease management model." When will this information be available?	The cost effectiveness information submitted to CMS in support of our waiver is included with this release of Q & A.
In the answers to Bidders questions from July 20th, on page 24, question number seven (7), it indicates DSHS will share cost information submitted to CMS (including costs to operate the	The cost effectiveness information submitted to CMS in support of our waiver is included with this release of Q & A.

program and claims costs) in order to assist bidders in determining cost neutrality. When will this information be available?	
In the answers to Bidders questions from July 20th, on page 25, question number 15, it indicates DSHS will post the public reports related to the previous disease management programs on the RFP website. When will this information be available?	The evaluation studies will be posted to our website.
In the answers to Bidders questions from July 20th, on page 28, question number 42 it indicates that due to a glitch in the system that created numbering errors on the RFP that the RFP would be renumbered and sent electronically. We want to ensure that our numbering matches the RFP document DSHS will be referencing. When and how will this corrected RFP be forwarded to bidders?	DSHS will not be renumbering the RFP questions. There is no Question 4 on page 32, and we will make sure our evaluation tool reflects the misnumbering. Also, please just label the cost proposal clearly as Section F, and start a separate section of your proposal for the cost questions.
The Claims and Client files appear to match with respect to the total number of recipients, but actual client identifiers (RECIP IND) are different across the two data sets. That is, recipients that appear in the Claims file do not appear in the Client file. Please provide explanation of the source, time periods (or point in time for Client file) and the inclusion/exclusion criteria for these two data sets, or an explanation of the significant .	See above answer.
If dual eligible clients are included, please verify the assumption that MEDICARE_PAID amounts reflect Medicare crossover claims. Additionally, please explain whether or not claims are included in the Claims file for periods outside which clients meet the inclusion/exclusion criteria for appearing in the Client file.	Yes. Yes they are included. They would be included based on department policies for payment of claims and clients eligibility may not be included if they are no longer eligible for any medical programs. Medicare eligible clients would have been removed from the eligibility file for DM, but claims would continue to be transmitted in the claims file for 12 months.
The total paid amount (AMT_PAID) appears to be higher than the total allowed amount (AMT_ALLOWED). Please provide an explanation (e.g. transposed column names).	This occurs when taxes are included in the paid amount. This may also occur in DRG claims. Also, if rates were adjusted to increase reimbursement amounts by the department.
Our understanding was that DSHS would provide one year of claims data. The Claims data file received appears to have claims from 1999 through 2006 (as evidenced by YearFDOS). Please confirm that the time period for claims data is 1999 though 2006, indicating whether calendar year or fiscal year is identified.	Yes. The claims data includes all claims paid between April 2004 and may 2006. Claims prior to 2004 may be included based upon department polices and procedures.
Do claims indicated for years other than 2005 represent all claims for each given year?	No.
Our understanding was that the Claims and Client files would use the inclusion/exclusion criteria that matched target population outlined in Section I.C.3 of the RFP (page 8). Please detail the inclusion/exclusion criteria used, and whether dual eligible clients are included.	The client file matches inclusion/exclusion criteria that applied to our former DM program, not to the new one. The data supplied to you is for the purpose of testing the Predictive Modeling system with a sample file of claims and eligibility, not to supply you with an exact set of clients who would be enrolled in the new program.

Client eligibility for previous DM population:
The eligible population includes clients with the following program/match code combination, all of whom have medical eligibility code of 0.

Program	Match	Description
A (Aged)	C	Categorically Needy (CN), income at/below CNIL
A	S	CN, income above CNIL
A	U	Aged non SSI
A	1,2	SSI grandfathered grant recipient (1); essential person (2)
B (Blind)	C	CN, income at/below CNIL
B	S	CN, income above CNIL
B	U	Blind non SSI
B	1,2	SSI grandfathered grant recipient (1); essential person (2)
P (Disabled)	C	CN, income at/below CNIL
P	S	CN, income above CNIL
P	1,2	SSI grandfathered grant recipient (1); essential person (2)
P	U	Disabled non SSI
X (Presumptive SSI)	G	Suspended grant – X cases eligible for less than $10, or in adult family home with income above CPI
X	U	All other presumptive SSI cases